Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
8108 FOX CREEK TRAIL
DALLAS TEXAS 75249

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN HOME ASSURANCE

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-2119-01

MFDR Date Received
November 19, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per MAR Fee Guidelines. Pre-Auth: PCID# 1000034729."

Amount in Dispute: $2,299.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider did not submit documentation showing that the services provided met the 'Specific Program Standards' for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual. See 28 TAC 134.202 (e)(5). For example, the documentation fails to show how the exercises were related to Claimant's actual job duties. Therefore, Provider is not entitled additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2004 through March 15, 2004	97550, 97565-WH and 97546-WH	$2,299.30	$1,740.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Former 28 Texas Administrative Code §134.202 sets out the fee guideline reimbursement for professional services provided between August 1, 2003 and March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 01390 – Fee Guideline MAR reduction
   - 01956 – Disallowed – service/procedure exceeds generally accepted medical guidelines
   - 02033 – Fee guideline MAR reduction
   - 01956 – No MAR
   - 03336 – FHN Contract status indicator 02 – non-contracted provider

Issues

1. Did the requestor submit documentation to support the billing of the work hardening services?
2. Did the requestor submit documentation to support the billing of the functional capacity evaluation?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.202 states in pertinent part, "(e) Payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows: (5) Return To Work Rehabilitation Programs. The following shall be applied for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a commission Return to Work Rehabilitation Program, a program should meet the "Specific Program Standards" for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual. Section 1 standards regarding Organizational Leadership, Management and Quality apply only to CARF accredited programs."
   - The requestor seeks reimbursement for CPT codes 97545-WH and 97546-WH rendered on March 2, 2004, March 8, 2004, March 9, 2004, March 10, 2004, March 11, 2004 and March 15, 2004.
   - The first two hours of each work hardening session shall be billed and reimbursed as one unit, using the "Work hardening/conditioning; initial 2 hours" CPT code with modifier "WH." Each additional hour shall be billed using the "Work hardening/conditioning; each additional hour" CPT code with modifier "WH."
   - Reimbursement for the work hardening program is $64.00 per hour. Units of less than 1 hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.
   - The requestor did not append the CA modifier to identify that the program is CARF accredited, as a result if the program is not CARF accredited, the only modifier required is the appropriate program modifier -WH. The hourly reimbursement for a non-CARF accredited program shall be 80% of the MAR.
   - Date of service: March 2, 2004: Disputed CPT code 97545-WH:

     The requestor billed and documented a total of 2 hours of CPT code 97545-WH per CMS 1500. Review of the SOAP note documents the start time at 8:15 am and the stop time at 4:15 pm. The insurance carrier issued payment for one unit at $51.20 for CPT code 97545-WH. The requestor documented two units and is therefore entitled to reimbursement for the second unit at $51.20. This amount is recommended.
   - Date of service: March 8, 2004: Disputed CPT code 97545-WH:

     The requestor billed and documented a total of 2 hours of CPT code 97545-WH per CMS 1500. Review of the SOAP note documents the start time at 8:30 am and the stop time at 4:30 pm. The insurance carrier issued payment for one unit at $51.20 for CPT code 97545-WH. The requestor documented two units and is therefore entitled to reimbursement for the second unit at $51.20. This amount is recommended.
   - Date of service: March 9, 2004: Disputed CPT code 97545-WH and 97546-WH:

     The requestor billed and documented a total of 8 hours of CPT codes 97545-WH and 97546-WH per CMS 1500. Review of the SOAP note documents the start time at 8:30 am and the stop time at 4:30 pm. The requestor documented the disputed charges and is therefore entitled to reimbursement for 2 hours of CPT code 97545-WH and 6 hours of CPT code 97546-WH for a total of 8 hours at $51.20/hour. Reimbursement is recommended in the amount of $409.60.

- Date of service: March 10, 2004: Disputed CPT code 97545-WH and 97546-WH:

  The requestor billed and documented a total of 8 hours of CPT codes 97545-WH and 97546-WH per CMS 1500. Review of the SOAP note documents the start time at 8:30 am and the stop time at 4:30 pm. The requestor documented the disputed charges and is therefore entitled to reimbursement for 2 hours of CPT code 97545-WH and 6 hours of CPT code 97546-WH for a total of 8 hours at $51.20/hour. Reimbursement is recommended in the amount of $409.60.

- Date of service: March 11, 2004: Disputed CPT code 97545-WH and 97546-WH:

  The requestor billed and documented a total of 8 hours of CPT codes 97545-WH and 97546-WH per CMS 1500. Review of the SOAP note documents the start time at 8:50 am and the stop time at 4:50 pm. The requestor documented the disputed charges and is therefore entitled to reimbursement for 2 hours of CPT code 97545-WH and 6 hours of CPT code 97546-WH for a total of 8 hours at $51.20/hour. Reimbursement is recommended in the amount of $409.60.

- Date of service: March 15, 2004: Disputed CPT code 97545-WH and 97546-WH:

  The requestor billed and documented a total of 8 hours of CPT codes 97545-WH and 97546-WH per CMS 1500. Review of the SOAP note documents the start time at 8:15 am and the stop time at 4:15 pm. The requestor documented the disputed charges and is therefore entitled to reimbursement for 2 hours of CPT code 97545-WH and 6 hours of CPT code 97546-WH for a total of 8 hours at $51.20/hour. Reimbursement is recommended in the amount of $409.60.

The requestor submitted sufficient documentation to support the billing of CPT codes 97545-WH and 97546-WH for the dates of service indicated above. As a result the requestor is entitled to additional reimbursement for each date of service in dispute.

2. 28 Texas Administrative Code §134.202 states in pertinent part, "(e) Payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows: (4) Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the commission shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using the "Physical performance test or measurement..." CPT code with modifier "FC." FCEs shall be reimbursed in accordance with subsection (c)(1). Reimbursement shall be for up to a maximum of four hours for the initial test or for a commission ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements..."

   - The requestor seeks reimbursement for a functional capacity evaluation rendered on February 16, 2004. Review of the CMS-1500 for date of service February 16, 2004 documents that the requestor billed for 16 units of 97750-FC. CPT code 97750 is billed in 15 minute increments for a total amount of time billed of 4 hours.
   - Review of the submitted documentation finds that the requestor submitted a copy of a functional capacity evaluation exam report dated March 15, 2004 documenting 5 hours spent on the exam. The requestor also included a copy of the ERGOS evaluation Summary Report and ERGOS Supporting Data Report dated February 16, 2004. The start time documented on the ERGOS evaluation Summary Report and ERGOS Supporting Data Reports indicate 12:30 pm with no end time.
   - Review of the documentation submitted by the requestor does not support the billing of 16 units of CPT code 97750-FC for date of service February 16, 2004, as a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,740.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,740.80 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06 due within 30 days of receipt of this Order.

Authorized Signature

		July 19, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.